Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ORTHOTEXAS PHYSICIANS
4780 NORTH JOSEY LANE
CARROLLTON TEXAS 75010

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

DALLAS ISD

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-3530-01

MFDR Date Received

June 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "denied as bundled but this is primary code & is not bundled to any other procedure."

Amount in Dispute: $1,542.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "According to the National Correct Coding Initiative Edits, procedure code 63047 is global to 22630. The enclosed explanation of benefits indicates the reduction code reflected this information as well as the statement in the comment section."

Response Submitted by: Argus Services Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2011	63047	$1,542.13	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedure for professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 16, 2011
   - 97A – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. "Per the National Correct Coding Edits."

Explanation of benefits dated May 25, 2011

- 193E – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. *Duplicate Appeal. An appeal of the original audit was previously performed for these services.*
- 97A – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. "Per the National Correct Coding Edits."

Issues

1. Did the requestor bill for services in conflict with NCCI edit?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT codes 63047 rendered on March 3, 2011.
2. 28 Texas Administrative Code §134.203 states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
   - The requestor billed CPT codes 63047, 63048 x 3 units, 22630 and 22612-80.
   - NCCI edits were run to identify if the disputed charges contain edit conflicts.
   - Per CCI Guidelines, Procedure Code 63047 has a CCI conflict with Procedure Code 22630. A modifier may be appropriate. Review of the submitted documentation does not document that a payment modifier was appended to CPT code 63047. Therefore, reimbursement cannot be recommended for CPT code 63047.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 14, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.